TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SPINECARE, LLP

Respondent Name
TPCIGA FOR CREDIT GENERAL INDEMNITY CO

MFDR Tracking Number
M4-16-3694-01

Carrier's Austin Representative
Box Number 50

MFDR Date Received
AUGUST 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Authorization was obtained prior to services being rendered…maximum allowable reimbursement (MAR) should be …$207.39."

Amount in Dispute: $114.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The recommended allowance of $93.08 made for CPT code 62370 is appropriate as this code is listed in the Medicare ASC Addendum AA with a payment indicator of 'P3', which is for an office-based procedure. The Medicare Fee Guidelines for Professional Services (§134.203) rates and guidelines apply to reimbursement for all office-based procedures with payment indicators P3 or Z3."

Response Submitted by: Texas Property & Casualty Insurance Guaranty Association

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 1, 2016	Ambulatory Surgical Care Services CPT Code 62370	$114.31	$105.32

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- P12-Workers compensation jurisdictional fee schedule adjustment.
- Charge exceeds fee schedule allowance.
- No payment adjustment for multiple procedures rules apply.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- This procedure is an office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUS; payment based on medical fee guidelines.

Issues

1. Did the requestor support position that additional reimbursement is due for ASC services for code 62370? Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   CPT code 62370 is defined as "Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)."

   CPT code 62370 is classified as a non-device intensive procedure.

   28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   Per Addendum AA, CPT code 62370 has a payment indicator of P3 – "Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs." Therefore, 28 Texas Administrative Code §134.402(h) applies to code 62370.

   28 Texas Administrative Code §134.402(h) states "For medical services provided in an ASC, but not addressed in the Medicare payment policies as outlined in subsection (f) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided."

   Per the MPFS, the MAR for CPT code 62370 rendered in Corpus Christi, TX is $198.40. The insurance carrier paid $93.08. The difference between the amount due and amount paid is $105.32. As a result, the amount recommended for additional reimbursement is $105.32.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $105.32.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $105.32 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		9/13/16
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.